Daniel M. Finley
County Executive

Cathy A.Bellovary
Director

Waukesha
COUNTY
DEPARTMENT OF SENIOR SERVICES

ELIGIBILITY APPLICATION
for the
TAXI and RIDELINE SPECIALIZED TRANSPORTATION PROGRAMS

Taxi Program

For Waukesha County residents, who are non or limited drivers, age 65 years or older, and able to enter or exit an automobile with little or no assistance.

AND Waukesha County residents, who are non-drivers under the age of 65, able to enter or exit an automobile with little or no assistance **and** receive either SSI or SSDI benefits. A SSI or SSDI Benefits Verification Form must be submitted with application and can be obtained from:

Social Security Office
707 North Grand Avenue
Waukesha, WI 53186
262-542-7253 or 1-800-772-1213

RideLine Program

For Waukesha County residents, who are non or limited drivers, age 65 years or older, unable to enter or exit an automobile and require an accessible vehicle, or have no taxi service in their community, or need to travel outside of the taxi service area.

AND for those Waukesha County residents who are non-drivers under the age of 65 years, unable to enter or exit an automobile and use either a wheelchair, scooter, cane, walker, crutches, or are legally blind.

Service to adjoining County ONLY for second opinions, consultations, or service NOT duplicated in Waukesha County with prior approval.

Please send or fax your completed application to:

Waukesha County Department of Senior Services
1320 Pewaukee Road Rm. 130
Waukesha, WI 53188

Phone (262) 548-7848 Fax (262) 896-8273

RideLine & Local Shared-Fare Taxi
APPLICATION FORM

Information provided on this application will be kept confidential and used by Waukesha Co. Dept. of Senior Services for determining eligibility for the specialized transportation programs. **If you need assistance filling out this form, call the Department of Senior Services at (262) 548-7848**.

PLEASE PRINT

Name_____ ☐ F ☐ M

Social Security #_____/_____/_____ Birthdate _____ Age_____

Address_____ Apt #_____

City/Village/Town _____ Zip _____

Daytime Phone: (____)_____ Evening Phone: (____)_____

Other family members living at the above residence: *[Please provide name, age and relationship to applicant]*_____

1. Are you receiving Medicaid (Title 19)? ☐ Y ☐ N

2. Are you receiving COP (Community Option Program) funding? ☐ Y ☐ N

3. Do you have a Social Worker? ☐ Y ☐ N
   Name _____Phone _____

4. Are you applying for taxi, under 65 years of age, and receiving SSI or SSDI?
   ☐ Y ☐ N If yes, submit a Benefits Verification Form with your application.

5. Do you own a vehicle? ☐ Y ☐ N Do you drive? ☐ Y ☐ N ☐ Sometimes

6. Do you have any driving restrictions or limitations? ☐ Y ☐ N
   If yes, please explain _____

7. Are you able to enter and exit a vehicle with little or no assistance? ☐ Y ☐ N

8. Is your disability or limitation temporary? ☐ Y ☐ N

9. Is your disability or limitation due to an accident or work-related injury? ☐ Y ☐ N
   If yes, is there an active claim with an insurance company? ☐ Y ☐ N

10. Do you use any of the following aides? ☐ Y ☐ N
    If yes, check all that apply:

☐ cane	☐ walker	☐ manual wheelchair	If oversized:
☐ white cane	☐ crutches	☐ powered wheelchair	length_____
☐ guide animal		☐ scooter	width_____
☐ portable oxygen		Are you able to transfer to a seat with	
☐ orthotic/prosthetic		little or no assistance? ☐ Y ☐ N	

Check all that apply:

☐ **Non-ambulatory:**
requires permanent use of a wheelchair

☐ **Respiratory Impairment:**
occurs when climbing steps or walking

☐ **Pacemaker:**
condition interferes with independent mobility

☐ **Cardiac Disease:**
resulting in marked limitation of physical activity

☐ **Restricted Mobility:**
condition causes difficulty walking; requires the use of a mobility aid

☐ **Nerve Root Compression Syndrome:**
causes pain and motion limitation in back or neck

☐ **Arthritis:**
Causes a functional motor defect in any two major limbs

☐ **Dialysis:**
requires use of kidney dialysis machine and causes post-treatment weakness

☐ **Diabetes:**
Condition status interferes with independent mobility

☐ **Spinal Disorders:**
causes motor and sensory loss, osteoporosis with pain, limit of movement

☐ **Visual Impairment:**
interferes with independent mobility; legally blind

☐ **Mental** or **Emotional Impairment:**
interferes with independent mobility

☐ **Hearing Impairment:**
interferes with independent mobility

☐ **Chemotherapy** or **Radiation:**
causes post-treatment weakness

☐ **Speech Impairment:**
interferes with independent mobility

☐ **Developmental Disabilities:**
interferes with independent mobility

☐ **Aging:**
limitations to mobility due to advanced age with fatigue and decreased energy level; restricted mobility and slowed response time;

☐ **Amputation of**
LEG: ☐ *right* ☐ *left*
ARM: ☐ *right* ☐ *left*

☐ **Autism:**
interferes with independent mobility

☐ **Neurological Impairment:**

☐ Cerebral Palsy	☐ Traumatic Brain Injury	☐ Epilepsy
☐ Multiple Sclerosis	☐ Parkinson's Disease	☐ Seizure Disorder
☐ Muscular Dystrophy	☐ Memory Loss or Dementia	☐ Other _____

Comments:

For **RideLine** applicants, an "attendant" is defined as "*a mobility aide to the passenger, necessary to facilitate the safe transportation of the passenger.*" In a very real sense, **if an attendant is deemed necessary** to provide mobility assistance or supervision to ensure safety beyond the basic door-to-door service provided by the RideLine program, **all travels will require an attendant and no rides can be arranged without one**.

Do you require an attendant when you travel? ☐ Y ☐ N

If someone other than the applicant will be arranging trips, provide his/her name and phone number:

Name _____ Phone (_____) _____

Emergency Contact Information

Provide information on *at least two* persons to be contacted in case of emergency

1. Name _____ Relationship _____
   Phone (_____) _____ Phone (_____) _____
2. Name _____ Relationship_____
   Phone (_____) _____ Phone (_____) _____

Authorization to Release Information

The physician listed below is familiar with my disability or medical condition, and is authorized by me to provide information to Waukesha County Department of Senior Services staff in order to complete the eligibility process or verify my application for subsidized specialized transportation services:

Physician Name: _____

Office Address: _____

Office Phone: _____

***Signature of Applicant:_____Date:_____**

I believe the information provided in this application is true and correct. I understand that deliberately providing false information is punishable by law and may jeopardize the receipt of services. I hereby authorize Waukesha County Department of Senior Services to verify the information in this application.

***Signature of Applicant:_____Date:_____**

Application being completed by a person other than the applicant, please complete the following:

Name _____ Relationship to Applicant _____

Agency Affiliation (*if appropriate*) _____

Address _____

City/Village/Town _____ Zip _____

Daytime Phone (___) _____ Evening Phone (___) _____

Signature _____ **Date** _____

Waukesha County Department of Senior Services
RIDELINE FARE DETERMINATION FORM

Name_____Birth Date_____

Address_____Apt #_____Zip_____

City_____Phone (____)_____

Do you receive Title 19? ___Yes ___No Do you receive COP funding? ___Yes ___No

If you receive Title 19 or COP (Community Option Program), do not complete the remainder of this page.

Choose OPTION A or OPTION B if you do not receive Title 19 or COP

OPTION A: I do not wish to divulge my financial information. I agree to pay the following fare:

One-way trip within the same community:	$7.25
One-way trip from one community to another	$9.75
One-way trip to an adjoining County (available ONLY for medical and ONLY if service is NOT available in Waukesha County):	$16.25

Signature_____Date_____

OPTION B: I have listed my financial information for the Department of Senior Services. The information will be used to determine my RideLine fares based upon my ability to pay.

		Passenger	*Spouse*
1)	Average Monthly Income:	$_____	$_____
2)	Average Monthly Medical Expenses	$_____	$_____
3)	Total Liquid Assets:	$_____	$_____

1) **Average Monthly Income**: include your social security, pension, disability, wages, interest/dividends, rental income, and any other income you may receive.

2) **Average Monthly Medical Expenses**: include medicine, medical supplies, health insurance premiums, and dental, doctor or hospital bills. DO NOT INCLUDE medical expenses paid for by Medicare, Medicaid, or other insurance.

3) **Total Liquid Assets**: include savings and checking accounts, investments (CD, stock, bonds).

This information is true and complete to the best of my knowledge. I authorize the use of this information by representatives of the Waukesha County Department of Senior Services for the purposes of fare determination. I understand this information will remain confidential.

Signature_____Date_____

Please return this completed form to: Waukesha County Department of Senior Services
1320 Pewaukee Road, Rm 130
Waukesha, WI 53188 OR FAX TO (262) 896-8273